PEDIATRIC INTAKE FORM

Date_____

Child's Name_____ Age_____ Sex_____Birthdate_____
Address_____
Phone_____

Parent/Guardian's Name_____
Address (if different from above)_____
Phone (Home)_____Phone (Work)_____

How were you referred to this office?_____
Name of Family Medical Doctor_____

CHIEF COMPLAINT

What is the chief concern about your child's health?_____
_____
_____
How long has this condition been present?_____
Has this condition been diagnosed by any other practitioner?_____
Have any specialists been consulted?_____
Until now how has this condition been treated?_____
_____
Are there any other concerns about your child's health? (For how long has each existed?)
1._____
2._____
3._____
4._____
5._____
How long has it been since your child was completely well?_____

PAST MEDICAL HISTORY

Please list the child's past medical history (Surgeries, Hospitalizations, Transfusions etc.)
1._____
2._____
3._____
4._____
5._____
Please list any accidents or trauma the child has suffered including when, severity and treatment
1._____
2._____
3._____
Please list any exposures the child has experienced (poisons, chemicals, sunburns etc.)
1._____
2._____
3._____
Is the child exposed to tobacco smoke? If yes, how often?_____

VACCINATIONS

Check any of the following immunizations your child has had.
Measles, Mumps, Rubella ❒ Diphtheria, Pertussis, Tetanus ❒ Polio ❒ Influenza ❒
Smallpox ❒ Hepatitis ❒ Other_____

If your child has ever had a negative reaction to a vaccination, what was the reaction, when was it given and what type of vaccine was it?_____
_____

PREVIOUS MEDICAL HISTORY (Please check those that are applicable)

Measles ❒	Sinusitis ❒	Hives ❒
Mumps ❒	Eczema ❒	Asthma ❒
Scarlet fever ❒	Pleurisy ❒	Eye Infections ❒
Whooping cough ❒	Herpes ❒	Diphtheria ❒
Croup ❒	Hay Fever ❒	Candida ❒
Pneumonia ❒	Chicken Pox ❒	Swollen Glands ❒
Tuberculosis ❒	Allergies ❒	Frequent Colds ❒
Ear Infections ❒	Influenza ❒	Tonsillitis ❒
Rheumatic Fever ❒	Other_____	

RECURRENT SYMPTOMS (Please check those that are applicable)

Nosebleeds ❒	Painful Urination ❒	Sore Throats ❒
Hyperactivity ❒	Frequent Urination ❒	Easy Bruising ❒
Strong Fears ❒	Bed Wetting ❒	Diarrhea ❒
Hearing Problems ❒	Blood In Urine ❒	Constipation ❒
Dizziness ❒	Tendency To Bleed ❒	Stomach Aches ❒
Hair Loss ❒	Body/Breath Odor ❒	Wheezing ❒
Night Sweats ❒	Change In Appetite ❒	Cough ❒
Sleep Problems ❒	Frequent Vomiting ❒	Nervousness ❒
Cries easily ❒	Other_____	

FAMILY HISTORY (Please indicate the age of all of the following relatives that are living and the age at which any have become deceased, L= living, D= deceased)

Brother L_____ D_____	Sister L_____ D_____
Brother L_____ D_____	Sister L_____ D_____
Father L_____ D_____	Mother L_____ D_____
Paternal Grandmother L_____ D_____	Maternal Grandmother L_____ D_____
Paternal Grandfather L_____ D_____	Maternal Grandfather L_____ D_____

Indicate the number of the above relatives that have or have had the following diseases:

Diabetes_____	Kidney Disease_____	Cancer_____
Mental Illness_____	Stomach Disorders_____	Arthritis_____
Alzheimer's Disease_____	High Blood Pressure_____	Goiter_____
Birth Defects_____	Heart Disease_____	Rheumatism_____
Allergies_____	Tuberculosis_____	

PRENATAL HISTORY - Mother's Health During Pregnancy (Please check applicable box)

Physical/Emotional Trauma ❒	Thyroid Problems ❒	Nausea ❒
High Blood Pressure ❒	Medications ❒	Illnesses ❒
Cigarette/Alcohol/Drug Use ❒	Bleeding ❒	Diabetes

Other_____
Mother's age at childbirth_____

BIRTH HISTORY - Term (Please check applicable box)
Full ❒ Premature ❒ Late ❒
Child's weight at birth_____ Length of labour_____ C-section or Vaginal birth?_____
Complications_____

Were any of the following experienced by your child at or soon after birth?

diarrhea ❒	birth defects ❒	rashes ❒
colic ❒	birth injuries ❒	jaundice ❒
vomiting ❒	seizures ❒	infections ❒

Other_____

MEDICATIONS & SUPPLEMENTS

Please list all medications that your child is currently taking - include dosage, frequency and name
1._____
2._____
3._____
4._____
Please list any medications to which your child has had an adverse reaction
1._____
2._____
3._____
How many courses of antibiotics has your child had in his/her lifetime ?_____
Please list any over the counter medications that your child has been given
1._____
2._____
3._____
Please list all supplements that your child is taking - include dosage, frequency and name
1._____
2._____
3._____
4._____
5._____

GENERAL INFORMATION

Please describe your child's sleep pattern_____
How many hours of sleep does your child average per 24 hour period ?_____
Does your child have any food sensitivities/intolerances/allergies that you are aware of ?_____
If so what are they ?_____
_____
What foods does your child crave ?_____
_____
Was your child breast fed ?_____ If so, for what period of time ?_____
For what period of time was your child fed formula ?_____cow's milk ?_____
soy milk ?_____ other ?_____
At what age did your child begin eating solid food ?_____
At what age did your child begin sitting ?_____ crawling ?_____ walking ?_____
speaking first words ?_____ gain his/her first full set of teeth ?_____